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9	BEFORE THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA					
10						
11	STATE OF CALIFORNIA					
12	In the Matter of the Accusation Against:	Case No. 2009-70				
13	SHANNON MARIE FARRELL, AKA	ACCUSATION				
14	SHANNON FORREST FARRELL, AKA SHANNON FORREST	ACCUSATION				
15	26982 Aldeano Drive Mission Viejo, CA 92691					
16	Registered Nurse License No. 542990					
17	Respondent.					
18						
19	Complainant alleges:					
20	<u>PARTIES</u>					
21	1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation					
22	solely in her official capacity as the Executive Officer of the Board of Registered Nursing					
23	("Board"), Department of Consumer Affairs.					
24	Registered Nurse License					
25	2. On or about April 24, 1998, the Board issued Registered Nurse License					
26	Number 542990 to Shannon Marie Farrell, also known as Shannon Forrest Farrell, and Shannon					
27	Forrest ("Respondent"). The registered nurse license will expire on March 31, 2010, unless					
28	renewed.					

#### STATUTORY PROVISIONS

- 3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.
- 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.
  - 5. Code section 2770.11 provides:
  - (a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by a committee. Any failure to comply with the provisions of a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.
  - (b) If a committee determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the committee shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.
    - 6. Code section 2761 states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct. . . .
- 7. Code section 2762 states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. .

and Safety Code section 11055, subdivision (b)(1)(M).

28

fraud, deceit, misrepresentation or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), by taking the drugs from hospital supplies for her own personal use.

- ii. Respondent possessed Vicodin, and Morphine, controlled substances, in violation of Code section 4060.
- iii. Respondent self-administered Vicodin, and Morphine, controlled substances, without direction from a licensed physician, surgeon, dentist or podiatrist.

# SECOND CAUSE FOR DISCIPLINE

# (Use of Controlled Substances - Danger to Others)

19. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (b), in that between in or around November 2003 to January 2004, on or about September 21, 2004, and between December 2004 and January 2005, while working as a nurse, Respondent used controlled substances in a manner dangerous or injurious to herself and others, as more fully set forth in paragraph 18, subparagraphs c(iii), d(iii), and e(iii), above.

#### THIRD CAUSE FOR DISCIPLINE

# (Grossly Inconsistent or Unintelligible Entries in Hospital or Patient Records)

20. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in Code section 2762, subdivision (e), as follows:

#### South Coast Medical Center

While working as a nurse at South Coast Medical Center in Laguna Beach,
California, Respondent made grossly incorrect, grossly inconsistent or unintelligible entries in
hospital or patient records as follows:

### Patient A

a. On or about December 21, 2004, at 0901 hours, Respondent signed out one 5/500 mg. tablet of Vicodin for Patient A when there was no physician's order for Vicodin for this patient. Respondent failed to chart the administration or wastage of any portion of the

Vicodin in any patient or hospital record or otherwise account for the disposition of the drug.

b. On or about December 21, 2004, at 0909 hours, Respondent signed out one 5/500 mg. tablet of Vicodin for Patient A when there was no physician's order for Vicodin for this patient. Respondent failed to chart the administration or wastage of any portion of the Vicodin in any patient or hospital record or otherwise account for the disposition of the drug.

#### Patient B

- c. On or about December 20, 2004, at 0915 hours, Respondent signed out a 4 mg./1ml. syringe of Morphine for Patient B, and at 1422 hours, Respondent signed out an additional 4 mg./1ml. syringe of Morphine for this patient. Respondent documented administration of 4 mg. of Morphine to Patient B on December 21, 2004, at 0905 hours, yet Respondent failed to chart the administration or wastage of the remaining 4 mg. of Morphine in any patient or hospital record or otherwise account for the disposition of the drug.
- d. On or about December 21, 2004, at 0922 hours, Respondent signed out a 2 mg./1ml. syringe of Morphine for Patient B, yet failed to chart the administration or wastage of any portion of the Morphine in any patient or hospital record or otherwise account for the disposition of the drug.
- e. On or about December 20, 2004, at 1641 hours, Respondent signed out a 2 mg./1ml. syringe of Morphine for Patient B, yet she charted that she administered the drug to patient B on December 20, 2004, at 1600 hours.

#### Patient C

f. On or about December 21, 2004, at 1209 hours, Respondent signed out a 2 mg/1ml. syringe of Morphine for Patient C, yet failed to chart the administration or wastage of any portion of the Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

# Patient D

g. On or about December 21, 2004, at 1103 hours, Respondent signed out one 5/500 tablet of Vicodin for Patient D, and at 1428 hours, Respondent signed out an additional 5/500 tablet of Vicodin for this patient. Respondent charted the administration of

Vicodin to Patient D at 0830 hours, yet failed to document the quantity of Vicodin administered.

# San Clemente Hospital

While working as a nurse at San Clemente Hospital in San Clemente, California, Respondent made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records as follows:

#### Patient AA

- h. On or about January 1, 2004, at 0632 hours, Respondent signed out two 5/500 mg. tablets of Vicodin for Patient AA, yet failed to chart the administration or wastage of any portion of the Vicodin in any patient or hospital record or otherwise account for the disposition of the drug.
- i. On or about January 7, 2004, at 0539 hours, Respondent signed out two 5/500 mg. tablets of Vicodin for Patient AA, yet failed to chart the administration or wastage of any portion of the Vicodin in any patient or hospital record or otherwise account for the disposition of the drug.

### Patient BB

j. Respondent's charting of administration of Vicodin to Patient BB does not correspond with Respondent's charting for signing out Vicodin for Patient BB, as follows:

Drugs <u>Withdrawn</u>			Drugs <u>Administered</u>	Administration <b>Date &amp; Time</b>	
Two Vicodin 7.5 mg./750 mg. tablets	Dec. 29, 2003	0730	Two Vicodin 7.5 mg./750 mg. tablets	Dec. 28, 2003	2435
Two Vicodin 7.5 mg./750 mg. tablets	Dec. 29, 2003	2405	Two Vicodin 7.5 mg./750 mg. tablets	Dec. 30, 2003	2000
One Vicodin ES	Dec. 30, 2003	2415	One Vicodin ES .	Jan. 4, 2003	0300
		. (	Two Vicodin ES	Dec. 31, 2003	0345
Two Vicodin 7.5 mg./750 mg. tablets	Jan. 6, 2004	0740	Two Vicodin 7.5 mg./750 mg. tablets	Dec. 31, 2003	0400
Two Vicodin ES	Dec. 31, 2003	0800	Two Vicodin ES	Jan. 4, 2003	0300

### Patient CC 1 On or around December 30, 2003, at 2100 hours, Respondent failed to k. 2 document the administration of 1 mg. of Morphine to Patient CC on Patient CC's medications 3 4 administration record. On or around December 30, 2003, at 2300 hours, Respondent failed to 1. 5 document the administration of 1 mg. of Morphine to Patient CC on Patient CC's medications 6 administration record. 7 **PRAYER** 8 WHEREFORE, Complainant requests that a hearing be held on the matters 9 herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision: 10 Revoking or suspending Registered Nurse License Number 542990, issued 1. 11 to Shannon Marie Farrell, also known as Shannon Forrest Farrell, and Shannon Forrest; 12 Ordering Shannon Marie Farrell, also known as Shannon Forrest Farrell, 2. 13 and Shannon Forrest, to pay the Board of Registered Nursing the reasonable costs of the 14 investigation and enforcement of this case, pursuant to Code section 125.3; and, 15 Taking such other and further action as deemed necessary and proper. 16 DATED: 9/23/08 17 18 19 RUTH ANN TERRY, M.P.H., R.N. 20 **Executive Officer** Board of Registered Nursing 21 Department of Consumer Affairs State of California 22 Complainant 23 SD2008800728 24 25 26 27

28